MINISTRY OF HEALTH AND
DEPARTMENT OF HEALTH
FOR SCOTLAND

A National Health Service

THE WHITE PAPER PROPOSALS IN BRIEF

NOTE: This is an official abridged version of the Government's proposals in their White Paper on a National Health Service. Every effort has been made to avoid discrepancies of terms or substance between this and the White Paper itself. If, however, any uncertainty arises, it is to the White Paper that the reader must look for explanation.

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NOTE : *For reasons of geography and local government structure there are certain differences, principally in matters of administration, in the arrangements proposed for Scotland. These differences are explained in a section on the Service in Scotland and elsewhere in the text ; where no difference is mentioned it should be understood that the proposals for England and Wales apply equally to Scotland with the necessary adaptations.*

A National Health Service

INTRODUCTORY

The Government have announced that they intend to establish a National Health Service, which will provide for everyone all the medical advice, treatment and care they may require.

This new service represents the natural next development in the long and continuous growth of the health services of the country. Although it forms part of the wider theme of post-war reconstruction —and although it will form an essential part of any scheme of social insurance which may be adopted—it has to be seen in the light of the past as well as the future and to be judged on its own merits as part of a steady historical process of improving health and the opportunity for health among the people.

In considering the form which the new National Health Service should take, the Government have had the help of informal discussions (in no way binding on those who took part in them) with representatives of the major Local Authorities, the Medical Profession, the Voluntary Hospitals and others. They now put forward definite proposals for discussion in Parliament and in the country, but they do not at this stage put the proposals forward as fixed decisions. Indeed, they have promised that those concerned, professionally and otherwise, shall be fully consulted before final decisions are taken. The Government will welcome constructive criticism and they hope that the next stage—the stage of consultation and public discussion—will enable them to submit quickly to Parliament legislative proposals which will be largely agreed.

I

SCOPE OF A NATIONAL HEALTH SERVICE

What the new service must offer

The new service is designed to provide, for everyone who wishes to use it, a full range of health care. No one will be compelled to use it. Those who prefer to make their own arrangements for medical attention must be free to do so. But to all who use the service it must offer, as and when required, the care of a family doctor, the skill of a consultant, laboratory services, treatment in hospital, the advice and treatment available in specialised clinics (maternity and child welfare centres, tuberculosis dispensaries and the like), dental and ophthalmic treatment, drugs and surgical appliances, midwifery, home nursing and all other services essential to health. Moreover, all these branches of medical care must be so planned and related to one another that everyone who uses the new service is assured of ready access to whichever of its branches he or she needs.

The new health service in all its branches will be free to all, apart from possible charges where certain appliances are provided. Questions of the disability benefits payable during sickness at home or during periods of free maintenance in hospital are matters for the Government's later proposals on social insurance.

Deficiencies in the existing services

A great deal of what is required is already provided in one or other of the existing health services. The problem of creating a National Health Service is not that of destroying services that are obsolete and bad and starting afresh, but of building on foundations laid by much hard work over many years and making better what is already good.

Yet there are many gaps in the existing services and much expansion and reorganisation are necessary to weld them into a comprehensive National Service. Despite the progress made it is far from true that everyone can get all the kinds of medical service which he requires. Nor is the care of health wholly divorced from ability to pay for it. To take one very important example, the first requirement is a personal or family doctor, available for consultation on all problems. The National Health Insurance scheme makes this provision for a large number of people, but not for wives or children or dependants—and it does not normally afford the consultant and specialist services which the general practitioner needs behind him. For extreme need, the Poor Law still exists. For particular groups, there are other facilities. But for something like half the population, the first-line service of a personal medical adviser depends on private arrangements.

So, too, in the hospital services, despite the well-known achievements of the voluntary hospital movement and more recently of the publicly provided hospitals of the local authorities, it is not yet true that everyone can be sure of the right hospital and specialist facilities which he needs, when he needs them.

Again, many existing services are provided—and excellently provided—by local authorities. But these services have grown up piecemeal to meet different needs at different times, and so they are usually conducted as separate and independent services. There is no sufficient link either between these services themselves or between them and general medical practice and the hospitals.

Need for a new attitude

Perhaps the most important point of all is the need for a new attitude towards health care. Personal health still tends to be regarded as something to be treated when at fault, or perhaps to be preserved from getting at fault, but seldom as something to be positively improved and promoted and made full and robust. Much of present custom and habit still centres on the idea that the doctor and the hospital and the clinic are the means of mending ill-health rather than of increasing good health and the sense of well-being. While the health standards of the people have enormously improved, and while there are gratifying reductions in the ravages of preventable disease, the plain fact remains that there are many men and women and children who could be enjoying a sense of health and physical efficiency which they do not in fact enjoy; there is much sub-normal health still, which need not be, with a corresponding cost in efficiency and personal happiness.

Closing the gaps

The Government's proposals for closing the gaps in the existing services and building a comprehensive National Service are described in the paragraphs which follow. For convenience, they are divided into four main sections dealing with General Medical Practice, Hospitals, Consultants, and Clinics and other Local Services. Short sections are added on Administration, on the Service in Scotland, and on Finance. Some of the proposals (e.g., a full dental or ophthalmic service) will take time to develop; the full national service cannot be built in a day. But the important thing is to make sure that the design is sound. Some of the proposals are controversial—that is inevitable. The Government hope, however, that their proposals, modified where modifications can be shown to be improvements, will win the approval of all those who will look to the new scheme for the promotion of their health, and the goodwill of those on whose willing service its success will depend.

II

GENERAL MEDICAL PRACTICE

Principles of a General Practitioner Service

The arrangements for general medical practice are the most important part of the proposals for a National Health Service. The family doctor is the first line of defence in the fight for good health; it is to him that every citizen using the new service will look for advice on his own health and the health of his family; and it is generally through him

that access will be had to the many other forms of medical care which the National Service will provide. If there is to be that high degree of confidence between doctor and patient on which the success of the new scheme will depend, two principles must be observed.

First, everyone must be free to choose the doctor whom he consults. Absolute freedom of choice is, of course, impracticable and does not exist now; the number of doctors in any one neighbourhood is necessarily limited. But there must be freedom to choose from among the doctors available.

Second, there must be no such regimentation in the scheme as will prevent a doctor from exercising his professional skill in whatever way he believes to be in the best interests of his patient. Yet, if the State is to provide a universal service of family doctors, there must be some degree of State intervention. The Government believe that their proposals preserve the right degree of balance in this.

Developments in medical practice

Another important point is the need to give free range to modern ideas as to the best form of general medical practice. To this problem much thought has been given in recent years, particularly by the profession itself. The idea of grouped practice—of individual doctors collaborating with each other in teams in which "many heads are better than one"—has received great prominence in professional and other discussions of late. The draft Interim Report of the Medical Planning Commission (organised by the British Medical Association) summarises the problem as follows:—

> "Diverse as are the views on the organization of medical services, there is general agreement that co-operation amongst individual general practitioners in a locality is essential to efficient practice under modern conditions, though views vary on the form of the co-operation. The principle of the organization of general practice on a group or co-operative basis is widely approved."

The Government fully agree that "grouped" practices, to which numerous privately arranged partnerships point the way, must be placed in the forefront of their plans for the National Health Service and their proposals are designed with this in view. But the conception of grouped practices cannot represent the whole shape of the future service. In the first place, there has not yet been enough experience of the idea translated into fact. Not enough has been found out, by trial and error, to determine the conditions under which individual doctors can best collaborate or the extent to which in the long run the public will prefer the group system. Secondly, it is certain that the system could not be adopted everywhere simultaneously. The change, even if experience shows that it should be complete, will take time.

The Government propose, therefore, that the new service shall be based on a combination of grouped practice and of separate practice, side by side. Grouped practices are more likely to be found suitable in densely populated and highly built-up areas and it is there particularly

(though not exclusively) that they will first be started. It will then be possible to watch the development, with the profession, and to decide in the light of experience how far and how fast a change over to this form of practice should be made.

Grouped practice and Health Centres

The conception of grouped practice finds its most usual expression in the idea, advocated by the Medical Planning Commission and others, of conducting practice in specially designed and equipped premises where the group can collaborate and share up-to-date resources—the idea of the Health Centre. The Government agree that in this form the advantages of the group system can be most fully realised, though it will also be desirable to encourage grouped practice without special premises. They intend to design the new service so as to give full scope to the Health Centre system.

The design of a Health Centre will provide for individual consulting-rooms, reception and waiting-rooms, simple laboratory work, nursing and secretarial staff, telephone services and other accessories, as well as—in varying degree according to circumstances—dark rooms, facilities for minor surgery and other ancillaries. The object will be to provide doctors with first-class premises and equipment and assistance and so give them the best facilities for meeting their patients' needs and saving their own time.

Health Centres will not affect the patient's freedom to employ the doctor of his choice: he will be equally free to choose his doctor, whether in a Health Centre, in grouped practice outside the Centre or in separate practice. Nor will the fact that a doctor is practising in a Health Centre mean that he will not visit his patient at home, when required, just as he does now. Each Centre will need to be so planned as to be regarded by patients, not as a complete break with present habit, but as a new place at which they can continue, if they wish, to see their own doctor in better equipped surroundings. Alternatively, they must be able, if they prefer it, simply to choose their Centre rather than any particular doctor in it; and then the Centre's arrangements must be such as to ensure that they are afforded all the proper advice and treatment there which they may need.

In England and Wales the Centres will normally be provided and maintained by county and county borough councils. The provision and distribution will be in accordance with a general plan for the operation in the area of the National Health Service as a whole. How this plan will be prepared is described later, but it will be drawn up in consultation with the medical profession and approved by the Minister. The wish of local doctors to bring their work into the Centres must obviously be a big factor in a decision to provide a Centre, but in the last resort the decision will rest on the public interest.

In Scotland, where the scale of the problem is smaller, the provision and maintenance of Centres will be a central responsibility of the Secretary of State, who will have power to delegate his functions to a local authority where, after an initial experimental period, this is shown to be desirable.

Separate practice

In this form of practice the general framework of the National Health Insurance scheme will (with important changes from the past) be retained. A doctor in separate practice will engage himself to provide ordinary medical care and treatment to all persons and families accepted by him under the new arrangements. He will work from his own consulting-room and with his own equipment, as he does now, but he will be backed by the new organised service of consultants, specialists, hospitals, laboratories and clinics of which he will be enabled and expected to make full use for his patients.

There will be no interference with the right of a doctor to go on practising where he is now and at the same time to take part in the new public service in that area. But for the purpose of securing a proper distribution of doctors some regulation of new entrants into any practice will be necessary.

A Central Medical Board

The Government contemplate that the general practitioner service will, in the main, be centrally organised and that the terms and conditions of service of the doctors taking part in the new scheme will be centrally arranged. As the doctors will be remunerated from public funds, the Minister himself must be ultimately responsible for the central administration. The Minister will, however, appoint a Central Medical Board which, acting under his general direction, will be responsible for much of the administration of the practitioner service. The Secretary of State will appoint a separate Central Medical Board for Scotland. The Board will in each case be the "employer" of the doctors who take part in the new service and it is consequently with the Board that the individual doctor will be in contract, whether he is engaged in separate practice or in group or Health Centre practice.

In the case of practice in Health Centres it would be difficult to place on local authorities the duty of providing, maintaining and staffing the Centres and give them no voice in the employment of the doctors who will work there. In this case, therefore, it is proposed that there should be a three-party contract between the Board, the local authority and the doctor. This will mean that a doctor employed in a Health Centre will be appointed by the Board and the local authority jointly, with his terms of service centrally negotiated and settled, and will be liable to have his service in the Centre terminated only by the joint decision of the Board and the local authority (or, if they fail to agree, by the Minister). This arrangement will not be required in Scotland, except where responsibility for maintaining Health Centres is delegated by the Secretary of State to a local authority.

The Board will also watch over the general distribution of public medical practice. In separate practice it will be the Board to whom application for consent must be made before a vacant public practice is refilled or a new public practice established—a consent which would be withheld only if there were already enough or too many

doctors in the area. In Health Centre practice it will be the agency through which, when vacancies occur, new doctors are introduced into a Centre.

The Board will be a small body, under a regular chairman—a few of its members being full-time and the rest part-time. Whilst it will be mainly professional, lay members will also be included. Since the Minister will be responsible for its policy, the Board must be appointed by him, but all appointments to it will be made in close consultation with the profession.

The local Insurance Committees of the National Health Insurance scheme will be abolished, and their day-to-day functions can be handled in each area by a local Committee of the Board on which local authority members will be included.

Remuneration and terms of service of doctors

The remuneration and terms of service of doctors taking part in the scheme are matters for discussion with the medical profession. The Government fully recognise the importance and urgency of reaching an understanding upon them and they think it right to put forward their general proposals on the subject.

Remuneration. As a mere problem of administration there would be no insuperable difficulty in devising a system under which all doctors engaged in public practice would be remunerated by salary. But this is a highly controversial question, on which opinions are sharply divided. Many experienced and skilled doctors would be unwilling to take part in a service so conceived. They would hold that if they became salaried servants—whether of the State or of local authorities—they would lose their professional freedom and be fettered in the exercise of their individual skill. Other doctors, with an equal right to be heard, would welcome a salaried service, believing that it would relieve them from business anxieties and enable them to devote themselves more freely to the practice of their profession. Lay opinion is similarly varied. The Government have approached the question solely from the point of view of what is needed to make the new service efficient. While they do not believe that a universal change to a salaried system is necessary to the efficient development of the service, and do not therefore propose this course, they consider that there will be parts of the new service to which different considerations will apply. It seems to the Government to be fundamental that in Health Centre practice the grouped doctors working together in a Centre should not be in competition for patients and that in this form of practice remuneration on a capitation system would be inappropriate. They therefore propose that doctors practising in Health Centres shall be remunerated by salaries or on some basis other than that of capitation fees, and they will be ready to discuss with the medical profession the precise system that should be adopted and the salary scales that would be appropriate.

It would also be possible, if desired by the doctors themselves, to offer remuneration by salary or on some similar basis to doctors

engaged in group practice, even where the practice was not conducted in a Health Centre and, perhaps, in certain circumstances, to doctors engaged in separate practice. Normally, the remuneration of a doctor in separate practice will be based (as it is now in National Health Insurance) on a capitation system, depending on the number of patients whose care he undertakes—the maximum number of patients whose care any one doctor ought to undertake being, of course, suitably regulated.

But, whatever methods of payment are adopted—capitation fee, salary or other—the substantial issue will be to decide what is, on ordinary professional standards, a reasonable and proper remuneration for the whole-time services of a general practitioner working in a public service. When that has been satisfactorily settled, remuneration under any system can be easily determined.

Terms of Service. It is not necessary at this stage to suggest the details of the contract into which a doctor who wishes to undertake public practice will enter with the Central Medical Board. But the contract will obviously need to provide :—

(1) for the doctor to give all normal professional advice and services within his proper competence to those whose care he undertakes ;

(2) for him to comply with the approved local arrangements for obtaining consultant and specialist and hospital services ;

(3) for proper machinery for the hearing of complaints by patients and for the general kind of disciplinary and appeal procedure already familiar in National Health Insurance ;

(4) for the observance of reasonable conditions, centrally determined with the profession, respecting certification and other matters which must arise in any publicly organised service.

Private practice

It is hoped that the great majority of doctors will take part in the new service and, therefore, it is not proposed to prohibit doctors who enter the service from also treating in their private practices any patients who do not desire to take advantage of the new public arrangements. It will be necessary in such cases to ensure that the interests of the patients in the public service do not suffer thereby and this will be done by reducing, as may be required, the number of persons a doctor is permitted to have on his list under the new scheme, and so reducing the remuneration he will receive from public funds. The position of the doctor paid by salary in a Health Centre presents greater difficulty but, as many doctors will bring most of their present practices with them to the public Health Centres, it will be necessary, during the experimental period at all events, to observe here the same sort of latitude as in the case of separate practice. In any event the volume of private practice will diminish greatly under the new scheme ; the essential point is that no person must have reason to believe that he can obtain more skilled

treatment by paying privately for it than he can within the public service.

Entry into the public service

There is a strong case for requiring young doctors, when they leave hospital and practise in the public service for the first time, to go through a short period as assistants to more experienced practitioners. The Government propose that this shall be the rule in future, though the Central Medical Board will be able to grant exemptions—e.g., where an assistant's post is not reasonably obtainable. The Board must also be able to require the young doctor during the early years of his career to give his full time to the public service when the needs of the service require this.

Compensation and superannuation

The proposals in this Paper would, in certain cases, destroy the selling value of existing practices, and where this is so compensation will be paid. Two classes of case, in particular, are likely to arise.

The first is that of a public practice in an " over-doctored " area, to the sale of which the Central Medical Board refuse consent. Here the out-going doctor or his representatives will be compensated.

The second is that of a doctor who gives up " separate " practice and takes service in a Health Centre. It would be incompatible with the conception of the Health Centre that practices within the Centre should be bought and sold and a doctor will therefore, by entering a Centre, exchange a practice having a realisable value for a practice which he will be debarred from selling. On the other hand, an efficient superannuation system will be an essential part of the Health Centre organisation. A doctor entering a Centre will acquire both superannuation rights and other facilities of considerable value. The proper course will be to strike a fair balance between what he gains and loses and to compensate him accordingly.

It will be more difficult to provide superannuation for doctors in separate practice, but the Government propose to consider whether an acceptable scheme can be devised for retirement within specified age limits and for superannuation on a contributory basis.

Sale and purchase of public practices

The Government have not overlooked the case which can be made for abolishing the sale and purchase of publicly remunerated practices. The abolition would involve great practical difficulty and is not essential to the working of the new service, and the Government intend to discuss the whole matter further with the profession, including any measures which may be needed to prevent the operation of the new public service from itself increasing the capital value of an individual practice, and therefore also the compensation which may later have to be paid.

Supply of drugs and medical appliances

The supply of drugs will need to be discussed with the appropriate pharmaceutical bodies. In particular it will be necessary to consider

the arrangements to be made for the supply of drugs to patients attending Health Centres.

As regards medical and surgical appliances, the existing system entitles an insured person to the supply, free of charge, of certain appliances specified in the Medical Benefit Regulations if ordered by a doctor. These " prescribed appliances " are, in the main, the articles most commonly required in general practice. In a service which includes treatment of all kinds, whether in or out of hospital, the range of necessary appliances will have to be greatly extended ; but it will be a matter for consideration whether the patient himself should not be called upon, if his financial resources permit, to contribute towards the cost of the more expensive appliances—or at least of repairs and replacements. This point will be of particular importance in connection with the dental and ophthalmic services.

III

HOSPITALS

Deficiencies in the present system

A fully organised system of hospitals will be the keystone of the National Health Service. The new hospital service must be complete and ready of access. It must include general and special hospitals, infectious disease hospitals, sanatoria for tuberculosis, accommodation for maternity cases, for the chronic sick and for rehabilitation. Ancillary hospital services must also be provided—for pathological examination, X-ray, electro-therapy, ambulances, and other purposes.

The high standard which many of the leading hospitals have attained needs no recommendation. They have shown the way in the development of hospital technique. But there are weaknesses in the present system and, to remedy these, two main problems have to be solved.

The first is to enable the two main hospital systems to work closely together in future for a common purpose. The voluntary hospital movement is well known in this country, not only as the oldest established hospital system here, but also as a movement which attracts the interest and support of many people who believe in it as a social organisation and wish to see it maintained. Its co-operation is essential to the success of the new service, side by side with the other steadily developing system of the publicly provided hospitals of the local authorities. The Government's proposals are based on the fullest co-operation between the two hospital systems in one common service.

The second problem is to determine the areas most suitable for hospital organisation, and bring together in a working plan for each area the various separate and independent hospitals. At present hospitals are not linked as they should be with one another and

with other health services, and their distribution is uneven. They have grown up without a national or even an area plan. In one area there may be already established a variety of good hospitals. Another area, although the need is there, is sparsely served. One hospital may have a long waiting list and be refusing admission to cases which another hospital not far away could suitably accommodate and treat at once. There is undue pressure in some areas on the hospital out-patient departments—in spite of certain experiments which some of the hospitals have tried (and which should be encouraged) in arranging a system of timed appointments to obviate long waiting. Moreover, even though most people have access to a hospital of some kind, it is not necessarily access to the right hospital. The tendency in the modern development of medicine and surgery is towards specialist centres—for radio-therapy and neurosis, for example—and no one hospital can be equally equipped and developed to suit all needs, or to specialise equally in all subjects. The time has come when the hospital services have to be planned as a wider whole, with the object of securing that each case shall be referred, not necessarily to the particular hospital which happens to be " local," but to whatever hospital can offer the most up-to-date technique for that kind of case. To achieve this object and to remedy the present lack of coherence, there is need of a single authority which has the duty to secure for the area for which it is responsible a complete hospital service.

The unit of administration

At present, hospital services which are publicly provided are mainly in the hands of county and county borough councils. The Government have no desire to disturb unnecessarily the present form of local government organisation or to interfere without cause in the work of these major local authorities. Indeed, it is their intention to base the local organisation of the new Health Service generally on these major authorities, operating over their own areas where possible and combining in larger joint areas only where necessary.

But it is abundantly clear that, with a few exceptions, counties and county boroughs are not large enough to serve as the area on which a unified hospital service could be based. For the purpose an area must fulfil three conditions :—

(a) Its population and financial resources must be sufficient to make possible an adequate, efficient and economical service.

(b) It should normally include both urban and rural areas so that the needs of town and country can be properly balanced.

(c) It should be such that most of the varied hospital and specialist services can be organised within its boundaries in a self-sufficient scheme (leaving for inter-area arrangement only certain specialised services).

In the great majority of the counties and county boroughs these three conditions would not be met.

The Government therefore propose that responsibility for the new

hospital service shall be entrusted to new joint authorities, which will be formed by combining for the purpose the existing county and county borough councils in joint boards operating over areas to be settled by the Minister after consultation with local interests at the outset of the scheme. There will be some exceptional cases (the County of London is the most obvious) where combination will be unnecessary. The powers and duties of present public hospital authorities will be transferred to the joint authorities, who will take over the ownership and management of all publicly owned hospitals.

An area hospital plan

The first task of each new joint authority will be to assess the hospital needs of its area and the available hospital resources, and to work out a plan of hospital arrangements for the area, based on using, adapting and where necessary supplementing the existing resources. All this will be done in consultation with local professional opinion and other local interests, including the voluntary hospitals. The plan will then be submitted to the Minister for approval and will have no validity until so approved.

The approved plan will define the parts to be played by the various hospitals, both the hospitals of the joint authority and the voluntary hospitals. Voluntary hospitals will not be compelled to participate in the plan, but the Government trust that they will not hesitate to do so since their collaboration will be of great importance to the success of the new hospital service. Indeed, without this collaboration it would be many years before the new joint authorities could build up a system adequate for the needs of the whole population.

Voluntary hospitals

Where a voluntary hospital agrees to participate in the new service, its participation will rest on a contract with the joint authority under which the hospital will undertake to provide the services specified in the area plan, and to abide by conditions applying to all hospitals and settled centrally for the country as a whole. A voluntary hospital accepting these arrangements will receive certain service payments from the joint authority—these service payments being in accord with centrally determined scales, and being less in amount than the total cost of the service rendered (for if the voluntary system is to be maintained, the voluntary hospital will still rely in large measure on its own resources, personal benefaction and on the continuing support of all who believe in the voluntary hospital movement). It will also receive from central funds certain payments in respect of its help in the scheme—payments which can, if the hospitals wish, be pooled in one fund from which the actual distribution to each hospital can take account of its particular needs. There will be no question of any interference in the internal management of voluntary hospitals, of the surrender by them of their independence and autonomy, or of any change in their status.

The Government will discuss their proposals in detail with repre-

sentatives of the voluntary hospitals and they trust that it will be possible—without infringing the principles on which they believe the National Health Service should be founded—to avoid injury to the voluntary movement, and to ensure the cordial collaboration of the voluntary hospitals in the new service.

Mental Hospitals

The inclusion of the mental hospitals in the National Health Service presents some difficulty until a full restatement of the law of lunacy and mental deficiency can be undertaken. Yet, despite the difficulties, the mental health services should be taken over by the new joint authority. This will be in accord with the principle, declared by the Royal Commission on Mental Disorder, that the treatment of mental disorder should approximate as nearly to the treatment of physical ailments as is consistent with the special safeguards which are indispensable when the liberty of the subject is infringed.

Hospitals for infectious disease

In the counties isolation hospitals for infectious diseases are with few exceptions owned and administered by the minor authorities and not by the county councils, and their transfer to the new joint authority will mean that their present owners will give up ownership without retaining even the part interest which membership of the new joint authority will afford in the case of hospitals belonging to county and county borough councils.

The case for this absolute transfer of the isolation hospitals has nothing to do with the past record of the minor authorities, nor is it in any way a reflection upon the quality of the work which they have hitherto done. The whole trend of medical opinion has for some time been in favour of treating these hospitals, not primarily as places for the reception of patients to prevent the spread of infection, but as hospitals where severe and complicated cases of infectious disease can receive expert treatment and nursing. The small isolation hospital of the past century is not only uneconomic in days of rapid transport but cannot reasonably be expected to keep abreast of modern methods. One result of the new outlook will be the development, in addition to the larger isolation hospital serving the densely populated area, of accommodation for infectious diseases in blocks forming part of the general hospitals. These considerations all indicate that the infectious disease hospitals must in future form part of the general hospital system.

Inspection of Hospitals

Apart from special inspections to enquire into difficulties that have arisen or changes that are in contemplation, routine inspections at not too frequent intervals will serve the double purpose of bringing to notice defects of organisation or management and, what is equally important, of enabling individual hospitals to be kept in touch with the latest practice and ideas. The foundation of any inspectorate must clearly be a team of highly qualified medical men, but the inspectors

need not all be persons employed whole-time on this work; there are advantages in employing on a part-time basis medical men or women distinguished in various branches of professional work or medical administration. In addition to doctors, there is scope for experts of various kinds for dealing with an organisation so varied and complex as a modern hospital. Hospital administrators, accountants, nurses, engineers, catering and kitchen experts—to mention no others—should find a place.

A solution would be the appointment by the Minister of a body of persons of the types mentioned, some on a whole-time and others on a part-time basis, grouped in suitable panels operating over different areas of the country. The part-time doctors would be selected partly from those associated with consultant practice and voluntary hospitals and partly from those with experience of municipal hospitals.

IV

CONSULTANTS

A Consultant Service based on Hospitals

Perhaps the most marked gap in the range of health services provided under the present National Health Insurance scheme is the lack of a consultant service. But it is not only among persons insured under the scheme that the need for such a service is felt, and a properly organised consultant service which will be fair to the consultants themselves and will ensure that everyone can obtain, whenever he needs it and without charge, the skilled advice of a specialist must have an important place in the new National Health Service.

The Government consider that a service of consultants can be best and most naturally based on the hospital services.

This means that it will become one of the duties of the joint authority to see that, through the various hospitals taking part, there will be provided an adequate consultant service which will ensure that the co-operation of consultants and specialists is fully available to all general practitioners in the service. It will do this, as in other branches of the hospital service, partly by its own direct arrangement and partly by contracting with the voluntary hospitals to provide consultant services—the arrangements made forming part of the local plan. The hospital will itself enter into the necessary engagements with the consultants and specialists concerned. The local service payments to the hospitals, already mentioned, will be based on the assumption of a consultant staff properly remunerated to enable the hospital to fulfil the tasks which it has undertaken to perform.

Some principles affecting consultant services

Before suggesting in detail the form of a consultant service the Government are awaiting the report of the Committee on Medical

Schools now sitting under the chairmanship of Sir William Goodenough. Meanwhile some general considerations of which account will be taken in devising the new service can be mentioned.

There are not yet enough men and women of real consultant status and one of the aims will be to encourage more doctors of the right type to enter this branch of medicine or surgery and to provide the means for their training.

There is also need for a more even distribution. The main consultant facilities are now inevitably concentrated at the medical teaching centres. The consultant service still needs to be organised with the teaching centre as its focus, but the service must be spread over a wider area by enabling and encouraging consultants taking part in it to live and work farther afield. Apart from greater accessibility to the public, this will also have a beneficial effect upon general medical practice over larger areas—where the habitual presence and services of consultants will serve as a means of continuing postgraduate education.

The consultant taking part in the service must be associated with his particular hospital or hospitals on a much more regular basis—and with more regular attendances and duties—than is often the case now, when he is regarded as merely " on call." It will often be desirable that he should be associated with more than one major hospital, so that the sharing of a common consultant staff may become an effective link between hospitals. His normal function will be the regular and frequent visiting of these hospitals, both for in-patient and for out-patient consultation ; also the visiting of outlying " general practitioner " hospitals, which need to be linked with the major hospitals ; also, for certain consultants as circumstances may require, the visiting of Health Centres and clinics and, in case of need, at the request of the general practitioner, of patients in their homes.

For this sort of duty the proper and regular remuneration of consultants, through the hospitals with which they are associated, will become essential. This remuneration, and the engagements entered into in respect of it, can be on either a full-time or a part-time basis (and might well include part-time engagements with more than one hospital).

The terms and conditions for these consultants will be a matter for the authorities of the hospitals, voluntary or municipal, which offer the appointments ; but in order to avoid anomalies as between hospital and hospital and between area and area some central regulation of remuneration will be required.

There will also be need for some control over the discretion of individual hospital authorities in making appointments to senior clinical posts. Under existing practice there is a danger of " in-breeding " ; and, while the ultimate responsibility for an appointment should rest unmistakably with the body of persons conducting the hospital's affairs, there is much to be said for a system under

which an expert advisory body would recommend a number of suitable candidates from which the hospital authority would make the final choice.

V

CLINICS AND OTHER LOCAL SERVICES

Services required

The National Health Service must include arrangements for home nursing, midwifery and health visiting; it must also include the local clinics and similar services which are now provided for maternity and child welfare and other special purposes, or which may have to be provided in the future. In England and Wales, the joint authority will have the duty of including all these local services in their general plan for the area and ensuring that they are properly related to each other and to the other parts of the National Service and are arranged in the right way and in the right place to meet the area's needs. The plan, as approved by the Minister, will finally determine in each area which of the services are to be provided and maintained by the county and county borough councils and which by the joint authority. Different arrangements will be necessary in Scotland, but the general principle in both countries will be that all the local services which belong to the sphere of general health care will rest with the major local authority, while those which belong to the hospital and consultant sphere will rest with the new joint authority.

Importance of work in clinics

As time goes on and the new scheme gets into its stride, there will be room for experiment and innovations in the way in which these various local services are provided. In particular, there will be opportunities for associating the family doctor more closely with the work of special clinics—e.g., child welfare centres. But, whatever developments there may be in the clinics and other locally provided services, the introduction of the new service will not mean that any existing facilities are abandoned, but rather that they will be increased and strengthened to meet the wider objects in view.

The way in which the Government's proposals, based on these principles, will affect the various services is described below.

Maternity and child welfare services

The arrangement of lying-in accommodation in hospital or maternity home (indeed all the institutional provision for maternity, both for normal and for complicated cases) will become part of the reorganised hospital and consultant services and will be the responsibility of the new joint authority. The ordinary functions of the maternity and

child welfare clinics, however—concerned, as they are, not primarily with direct medical treatment but more with giving advice on the bringing-up of young children and the problems of motherhood—will not be transferred to the new joint authority, but will lie wherever the related functions of child education are made by Parliament to lie under the new Education Bill. Under the present proposals in that Bill, this will mean that the county and county borough councils will be the authorities primarily responsible, but that arrangements will be made in suitable cases for the delegation of much of the practical care of the service to some of the existing authorities, within the counties, which have hitherto carried the responsibility and have accumulated good experience and local interest.

In Scotland there will be no change in the present arrangements for maternity and child welfare centres which are already being administered by the major local authorities in that country, the county councils and the town councils of the large burghs.

School Medical Service

For this service also the Government's proposals are related to the proposals in the Education Bill. It is contemplated that the education authorities will retain as part of their educational machinery the functions of inspection of children in the school group (the supervision, in fact, of the state of health in which the child attends school and of the effects of school life and activities on the child's health), together with the important function of using the influence of the school to ensure that the child receives any medical treatment he requires. But, as from the time when the new Health Service is able to take over its comprehensive care of health, the child will look for treatment to that service.

Tuberculosis dispensaries and other infectious disease work

The local tuberculosis dispensaries will in future be regarded as out-patient centres of the hospital and consultant services, and responsibility for them will normally rest directly with the new joint authority dealing with the whole of this aspect of the new service over its wider area.

Similarly, isolation hospital responsibilities will pass to the new joint authority as part of the general hospital problem of its area. But many of the measures dealing with the notification of diseases and the local control of the spread of infection, which are already the subject of statutory powers under the Public Health Acts, can still be suitably carried out locally in the different parts of the joint authority's area, although most of these activities will probably in future have to be centred in the county and county borough councils rather than distributed more widely, as they are now, among the minor authorities.

Cancer centres

Responsibility for the local centres of diagnosis and advice which were contemplated when the Cancer Act of 1939 was passed, but have

had little chance to develop substantially during the war, will pass with the other responsibilities of that Act to the new joint authorities as a part of the general hospital and consultant service.

Venereal diseases

The service for venereal diseases is at present in the hands of the county and county borough councils, and its allocation between those authorities and the new joint authority presents difficulty. In one sense it is essentially a clinic service which could continue to be locally organised within the framework of the new general area plan and need not be regarded as part of the wider hospital and consultant field. The newly developing use—started during the war—of the help of individual general practitioners to supplement the work of the clinics lends some point to this. On the other hand, it is a service requiring a high degree of specialisation and it is as a matter of convenience one which is usually attached to hospital premises; these are factors which point to associating it with the reorganised hospital service. It is something of a "border-line" case, and will be best left to be determined in the settlement of the area plan in each case.

New Services

Home nursing. A full home nursing service must be one of the aims of the new service. How far it needs to be directly provided by public authority, or indirectly by arrangements made with other bodies, or both, will be matters for discussion. Its object must be to ensure that those who need nursing attention in their homes will be able to obtain it without charge through the new service.

It is contemplated that the task of securing this will be entrusted to county and county borough councils.

Dental and ophthalmic services. A full dental service for the whole population, including regular conservative treatment, must unquestionably form part of the new National Health Service. But there are not at present, and will not be for some years to come, enough dentists in the country to provide it. Until the supply can be increased attention will have to be concentrated on priority needs. These must include the needs of children and young people, of expectant and nursing mothers, and it is these needs which must first be met. The whole dental problem is a peculiarly difficult one, and a Committee under the chairmanship of Lord Teviot has been set up by the two Health Ministers to consider and report on it.

There may be similar (though perhaps less acute) difficulties in getting a full service in ophthalmology. But these, like the difficulties in dentistry, must be treated rather as practical problems arising in the operation of a new service than as matters of doubt in planning its scope and objectives.

Health Centres. The arrangements for the local provision of Health Centres have been already mentioned as the responsibility normally of the county and county borough councils.

VI

ADMINISTRATION

Central Organisation

The main lines on which the Government propose that the new National Health Service shall be organised will have become clear from the arrangements already described for the various parts of the service. But the form of organisation contemplated may be easier to understand if it is summarised here as a whole. Moreover, there are important proposals affecting the administration of the new service which have not yet been mentioned.

It is proposed that central responsibility for the National Service shall rest on the two Health Ministers. Indeed, no other arrangement is possible, having regard to the magnitude of the scheme and the large sums of public money that will be involved.

While the service will thus be under general Ministerial control, only one part of it (the new general practitioner service) will be in the main centrally administered, and for most parts of the new service the principle already adopted in the majority of the health services in the past—the principle of local responsibility, with co-ordination at the centre—will be similarly adopted in the future. In the general practitioner service, however, much of the day-to-day administration will be carried out, under the general directions of the Health Ministers, by the two Central Medical Boards already described.

Central Health Services Council

Although it is on the Health Ministers that responsibility to Parliament for the new Health Service must rest, the Government attach great importance to ensuring that the service is shaped and operated in close association with professional and expert opinion. The provision of a health service involves technical issues of the highest importance, and in its administration, both centrally and locally, the guidance of the expert must be available and must not go unheeded. Otherwise the quality of the service is bound to suffer.

The Government propose, therefore, that there shall be set up by statute at the side of the Minister a special professional and expert body, to be called the Central Health Services Council. Its function will be to express the expert view on technical aspects of the Health Service. The Council will differ from the Central Medical Board in that it will be a consultative and advisory body, and not—as the Board will be—an executive body responsible under the Minister's direction for a defined part of the administration of the new Service. The Council will be entitled to advise, not only on matters referred to it by the Minister, but on any matters within its province on which it thinks it right to express an expert opinion. A duty will be placed on the Minister—apart from any other publication of the Council's advice or views which he may make from time to time—to submit annually to Parliament a report on the Council's work during the year.

The constitution of the Council will be considered in detail with the professional and other organisations concerned. It must be primarily medical in its make-up—though not wholly so, because it will be required to express views on many questions, e.g., of hospital administration, dentistry, nursing, midwifery and pharmacy, which will involve experts other than the surgeon or physician. It is contemplated that it might consist of some thirty or forty members, representing the main medical organisations, the voluntary and publicly owned hospitals (with both medical and other representation), medical teaching and professions like dentistry, pharmacy and nursing and midwifery. The Council will be appointed by the Minister in consultation with the appropriate professional bodies, and it will select its own chairman and regulate its own procedure. The Minister will be prepared to provide the secretariat and the expenses of the Council will be met from public funds.

A similar but separate body will be set up for Scotland by the Secretary of State.

Local Organisation

In framing their proposals for the local organisation of the new Health Service, the Government have been anxious to interfere as little as possible with the shape of representative local government. They have set out to base the new service as far as possible on the existing major local authorities, the county and county borough councils. But the requirements of the service will demand, for certain purposes, larger areas of operation or planning than the present counties and county boroughs can usually provide; for these purposes therefore it will be necessary for the counties and county boroughs to act in combination as joint authorities established over appropriate areas by the Minister, rather than in their separate capacities over their present areas. Thus, for reasons stated earlier, it is essential to its efficiency that the new hospital service shall be based, with a few exceptions, on areas larger than counties and county boroughs, and it is on this ground that the Government have proposed the establishment of joint authorities to administer that service—a proposal which still maintains for the county and county borough councils an interest in hospital administration inasmuch as they will be the constituent bodies of the new combined authority.

It is clear, for reasons also given already, that the joint authority responsible for the hospital service must also be responsible for the consultant service and such clinic and other local services as need to be organised in close association with the hospitals.

Preparation of local area plan

One further and important duty will be placed on the new joint authorities—that of preparing a rational and effective plan for all branches of the Health Service in their area.

The preparation of this plan has been referred to already in the description of the arrangements for the hospital and other individual services. But the intention is that the plan shall cover, not merely

the particular services which the joint authority will itself administer, but the whole range of services of which the National Health Service will be composed. Unless provision is made for the interlocking of the various parts of the service it cannot possess the coherence and unity of purpose which are essential features of the Government's proposals.

The preparation of a comprehensive plan of this kind is a function appropriate to the joint authority and not to its constituent members. The plan will be submitted to the Minister for approval, and when approved it will determine how the needs of the area in terms of general practice, hospitals, consultants, clinics and all other necessary services are to be met and will define, subject to the principles laid down, the responsibilities of the various authorities.

The plan will be open to amendment at any time by the same procedure. Both in its preparation and in its amendment the authority will fully consult local professional and expert opinion, through the medium of a Local Health Services Council.

Local Health Services Councils

Expert guidance is no less needed locally than it is at the centre. To meet the local need the Government propose that there shall be established, for the area of every joint authority, a Local Health Services Council. These Councils will be the local counterparts of the Central Health Services Council. Their constitution will call for more detailed consideration later but, provided that all the professional interests are fairly represented, there is no reason why the pattern should be precisely uniform everywhere—and the matter might be dealt with by local schemes approved by the Minister. The Councils will be able not only to advise on matters referred to them by the joint authority or other local authorities in the area, but also to initiate advice on any matters within their expert province on which they think it right to do so. They will be free, if they wish, to submit their views and advice not only to the joint authority or, on matters affecting other local authorities in the area, to those authorities, but also to the Minister. The joint authority will be required to consult the Council on the area plan for the health service before it is submitted to the Minister, and on any subsequent material alterations or additions to the plan.

VII

THE SERVICE IN SCOTLAND

Certain differences essential

The scope and purpose of the National Health Service will be the same in Scotland as it is in England and Wales, but the administrative structure of the service in the two countries cannot be identical.

Account must be taken of certain differences of geography and local government organisation in Scotland. For example, about 80 per cent. of Scotland's population is concentrated in about 17 per cent. of the total area of the country, across its industrial "waist." Outside the industrial belt are large, and for the most part sparsely populated, areas. Of the 55 existing health authorities in Scotland only 10 have populations of more than 100,000, and 32 have a population of under 50,000. Against this, the population of England and Wales is on the whole much more urbanised and the local government units are larger with correspondingly greater resources.

There will be no substantial difference in the central machinery to be set up in Scotland as compared with England and Wales, but the arrangements proposed for the local organisation of the service will need to be modified to suit the special circumstances of Scotland.

Regional Hospitals Advisory Councils

In England and Wales the new joint authorities will have the dual function of administering the hospital and allied services and of planning the health service as a whole. To make a similar arrangement in Scotland would usually be out of the question. The point can best be illustrated in relation to the hospital service. Successive Committees on hospital problems have emphasised the need for planning and co-ordinating the hospital service in Scotland over wider areas and for this purpose have recommended the selection of the four natural regions based on the Cities of Glasgow, Edinburgh, Aberdeen and Dundee, where the key hospitals as well as the medical schools are to be found, with a fifth based for geographical reasons on Inverness. Although areas of this size are necessary for the planning and co-ordination of a comprehensive hospital service, they are clearly too large to serve as administrative units. This means that co-ordination of the hospital service and responsibility for its actual provision have in Scotland to be separated in a way which does not apply to England and Wales.

Accordingly the Government propose to adopt the recommendations made by various Committees, including the Committee on Scottish Health Services and the Hetherington Committee, that a Regional Hospitals Advisory Council should be set up in each of the five regions referred to. The Council will consist of members nominated in equal numbers by the Joint Hospitals Boards of the combined local authorities in the region, described in the next paragraph, and by the voluntary hospitals, and an independent chairman will be appointed by the Secretary of State. In addition, it might include a small number of representatives of the medical and medical-educational interests of the region. The functions of the Councils will be consultative and advisory. They will advise the Secretary of State on the measures necessary to secure the co-ordination of the hospital and consultant services within the region.

Joint Hospitals Boards

The actual administration of the hospital and consultant services will be entrusted to Joint Hospitals Boards to be set up for smaller areas within the regions. The Boards will be composed entirely of representatives from the county councils and the town councils of large burghs in the area concerned. They will take over the whole ownership of and responsibility for the hospitals of their constituent authorities, will be charged with the statutory duty of securing a proper hospital service for their area—by their own provision and by arrangements with other Joint Hospitals Boards or voluntary hospitals—and will in fact be, so far as executive responsibility for the hospital service is concerned, the counterparts of the new joint authorities in England and Wales.

The Joint Hospitals Boards will have the duty of preparing a scheme for the hospital services of their area, after consultation with the voluntary hospitals. They will be encouraged also to consult the Regional Hospitals Advisory Council at this stage to secure the fullest measure of agreement between the scheme and the wider regional arrangements proposed by the Council. The Joint Hospitals Board will then submit their scheme to the Secretary of State, who will consult the Regional Hospitals Advisory Council to obtain their final views before deciding to approve or amend the scheme.

Clinics and other Services

The arrangements proposed for the planning and administration of the clinic services in England and Wales will also require some modification in their application to Scotland. The same general principle will be observed—namely, that the services more nearly allied to the hospital service will be made the responsibility of the new Joint Boards. Tuberculosis dispensaries and cancer clinics are the most notable examples. As the Joint Hospitals Boards will have no planning functions outside the hospital and consultant sphere, it is proposed to leave the remainder of the clinic services where they now are, in the hands of the major health authorities, and to give power to the Secretary of State to require these authorities (after a public local inquiry) to combine for any purpose where this is proved necessary for the efficiency of the new health service as a whole.

Local Medical Services Committees

The only remaining differences between the proposals for England and Wales and those for Scotland relate to the general practitioner service; they are two.

The first proposal—that in Scotland Health Centres will be provided and maintained by the Secretary of State—and the reasons for it have already been explained (page 7).

The second is that, in lieu of the Local Health Services Councils to be set up in England and Wales, there will be created in Scotland,

for every Joint Board area, a Local Medical Services Committee. The Committees will be to some extent similar to the Councils, but they will have a wider function. It will be their duty both to advise the Secretary of State on the development of the general practitioner service—the need for Health Centres, for example—and to act as a means of liaison between the general practitioner service and the other parts of the health service.

With these wider functions in view it is proposed that the Local Medical Services Committees shall consist of representatives of all the major local authorities in the area, of the local medical, dental, pharmaceutical and nursing professions, and of other interests closely concerned with the health services.

VIII

FINANCE

Cost to public funds

It is not possible within the limits of a short paper to explain in detail how the new Health Service will be financed ; for that, reference must be made to the White Paper itself. But the present paper would not be complete if it did not give some indication of the scale of expenditure involved and of how it will be met.

It is estimated that in England and Wales the total annual cost of the National Health Service to public funds will be not less than £132 millions, as compared with about £55 millions from public funds spent on the present health services.

Of this sum of £132 millions about £70 millions will be spent by the new joint authorities on the hospital, consultant and other services which they will provide and maintain themselves, including payments made to voluntary hospitals for their services under the area plan.

About £22 millions will be spent by county and county borough councils on the services for which they are to be directly responsible.

The State will itself spend directly about £30 millions on the new general practitioner service—including payments to chemists.

(The remaining £10 millions is the part of the expenditure of voluntary hospitals which will be met by a direct grant from the State.)

State grants

Apart from its own direct expenditure on the general practitioner service, the State will give grants to local authorities and to voluntary hospitals. The arrangements proposed are as follows :—

(1) A hospital grant of £100 a bed (£35 in mental hospitals and infectious disease hospitals, because of their lower comparative costs and because the scheme broadly does not impose any

additional duties on local authorities for treatment in these cases) will be paid to joint authorities in aid of the hospital and consultant service. A similar grant will be paid to voluntary hospitals (the £10 millions referred to above).

(2) Every new service, other than the hospital and consultant service, will be assisted by a 50 per cent. grant which will be paid to the authority responsible for the service.

(3) When the above grants have been paid the joint authorities will meet the remainder of their expenditure by precept upon their constituent county and county borough councils. These councils will meet the precept and their expenditure on their own services by a rate charge, but the charge will be mitigated by an additional Exchequer grant amounting to 50 per cent. of the increase in the total cost of the health services in any year over the cost in a selected standard year. The grant will be adjusted to give more help to poor areas and less to rich.

Cost to taxpayer and ratepayer

How far the central funds will consist of, or be assisted by, sums of money set aside out of contributions under a social insurance scheme will be considered later. The Beveridge Report proposed that an annual sum of about £40 millions should be available from this source for the new health services. Of this, nearly £36 millions would be the share appropriate to England and Wales, and if this assistance is assumed the approximate proportions in which the total cost of the new service will fall on the social insurance scheme, the taxpayer and the ratepayer will be (ignoring the effect of the block grant under the Local Government Act, 1929), as follows :—

Social insurance scheme	£36	millions.
Taxpayer	£48	„
Ratepayer	£48	„
	£132	

Finance in Scotland

It is estimated on the same basis that the total cost to public funds of the scheme in Scotland will be nearly £16 millions, of which about £3½ millions will be spent by the State on the practitioner service and Health Centres, about £8 millions by the new joint boards, about £3 millions by the county and large burgh councils and about £1½ millions will be paid direct to voluntary hospitals.

If it is assumed that Scotland's share of any sum set aside under a social insurance scheme will be about £4¼ millions (corresponding to the figure of nearly £36 millions for England and Wales) the total cost of the new service will fall on the social insurance scheme, the taxpayer and the ratepayer in approximately the following proportions :—

Social insurance scheme	£4.3	millions
Taxpayer	£6.1	„
Ratepayer	£5.4	„
	£15.8	

IX

SUMMARY OF PROPOSALS

1. *Scope of the new Service.*

(a) A National Health Service will be established. This service will be available to every citizen in England, Scotland and Wales.

(b) There will be nothing to prevent those who prefer to make private arrangements for medical attention from doing so. But, for all who wish to use the service it will provide a complete range of personal health care—general and specialist, at home, in the hospital and elsewhere.

(c) The service will be free, apart from possible charges for certain appliances. (Questions of disability benefits will be dealt with in later proposals on social insurance.)

2. *Structure of the Service.*

(a) *Central.*

(i) Central responsibility to Parliament and the people will lie with the Minister of Health and the Secretary of State for Scotland.

(ii) At the side of the Minister there will be a professional and expert advisory body to be called the Central Health Services Council. The Council will be a statutory body and its function will be to provide professional guidance on technical aspects of the Health Service. There will be a similar body in Scotland.

(b) *Local.*

(i) Local responsibility will be based on the county and county borough councils, which are the major local government authorities now. They will administer the new service partly in their present separate capacities over their present areas, partly—as the needs of the service require—by combined action in joint boards over larger areas.

(ii) Areas suitable for hospital organisation will be designated by the Minister after consultation with local interests.

(iii) The county and county borough councils in each area will combine to form a joint authority to administer the hospital, consultant and allied services; in the few cases where the area coincides with an existing county area the authority will be the county council of that area.

(iv) At the side of each new joint authority there will be a consultative body—professional and expert—to be called the Local Health Services Council.

(v) Each joint authority will also prepare—in consultation with the Local Health Services Council—and submit for the Minister's approval an "area plan" for securing a comprehensive Health Service of all kinds in its area.

(vi) County and county borough councils combining for these duties of the new joint authority will also severally be responsible for the local clinic and other services in accordance with the area plan. Responsibility for child welfare will be specially assigned in whatever way child education is assigned under the current Education Bill.

3. *Hospital and consultant Services.*

(a) It will be the duty of the joint authorities themselves to secure a complete hospital and consultant service for their area—including sanatoria, isolation, mental health services, and ambulance and ancillary services in accordance with the approved area plan.

(b) The joint authorities will do this both by direct provision and by contractual arrangements with voluntary hospitals (or with other joint authorities) as the approved area plan may indicate.

(c) The powers of present local authorities in respect of these services and the ownership of their hospitals will pass to the joint authority.

(d) Voluntary hospitals will participate, if willing to do so, as autonomous and contracting agencies; if so, they will observe the approved area plan, and certain national conditions applying to all hospitals in the new service alike; they will perform the services for which they contract under the plan, and receive various service payments from both central and local funds.

(e) Special provision will be made for inspection of the hospital service through centrally selected expert personnel.

(f) Consultant services will be made available to all, at the hospitals, local centres, or clinics, or in the home, as required; they will be based on the hospital service, and arranged by the joint authority, either directly or by contract with voluntary hospitals under the approved area plan.

(g) Measures for improving the distribution of consultants, dealing with methods of appointment and remuneration, and relating the consultant service to other branches of the new service generally, will be considered after the report of the Goodenough Committee.

4. *General Medical Practice.*

(a) Everyone will be free, under the new Health Service, to choose a doctor—the freedom of choice being limited, as now, only by the number of doctors available and the amount of work which each doctor can properly undertake.

(b) Medical practice in the new service will be a combination of grouped and separate practice.

Grouped practice means practice by a group of doctors working in co-operation.

Separate practice means practice by a doctor working on his own account—broadly similar to practice under the present National Health Insurance scheme, but with important changes.

(c) Grouped practice will be conducted normally, though not exclusively, in specially equipped and publicly provided Health Centres. In England and Wales, the Centres will be provided and maintained by county and county borough councils—in Scotland, by the Secretary of State with power to delegate to a local authority.

(d) General practice in the National Health Service will be in the main organised centrally under the responsible Health Ministers. All the main terms and conditions of the doctor's participation will be centrally settled, and much of the day-to-day administration will be the function of Central Medical Boards —one for England and Wales and one for Scotland—largely professional in composition, and acting under the general direction of the Health Ministers.

(e) The main duties of each Board will be :—

(i) to act as the " employer " of the doctors engaged in the public service. Thus, the Board will be the body with whom every doctor will enter into contract. In the case of practice in Health Centres in England and Wales, however, there will be a three-party contract between the Board, the local authority and the doctor.

(ii) To ensure a proper distribution of doctors throughout the country. For this purpose the Board will have power to prevent the taking over of an existing public practice or the setting up of a new public practice in an area which is already " over-doctored."

(f) It is not proposed that there should be a universal salaried system for doctors in the new service. Doctors engaged in Health Centres will be remunerated by salary or the equivalent ; doctors in separate practice normally by capitation fee. In some cases—e.g. grouped practice not based on a Health Centre—remuneration by salary or the equivalent could be arranged if the doctors concerned so desired. Rates of remuneration will be discussed with the medical profession.

(g) It is not proposed to prohibit doctors in public practice from engaging also in private practice for any patients who still want this. Where a doctor undertakes private in addition to public practice, the number of patients he is permitted to take under the National Service—and consequently his remuneration—will be adjusted.

(h) Young doctors entering individual practice in the public service

for the first time will normally be required to serve for a period as assistants to more experienced practitioners, and the Board will be able to require them to give full time to the service if necessary.

(j) Compensation will be paid to any doctor who loses the value of his practice—e.g. by entering a Health Centre or because he is prohibited from transferring the practice to another doctor on the ground that there are too many doctors in the area.

Superannuation schemes will be provided for doctors in Health Centres and the possibility of providing them in other forms of practice will be discussed with the profession, and the practicability of abolishing the sale and purchase of public practices will be similarly discussed.

(k) Arrangements for the supply of drugs and medical appliances will be considered and discussed with the appropriate bodies.

5. *Clinics and other services.*

(a) It will be the duty of the joint authority to include in its area plan provision for all necessary clinics and other local services (e.g., child welfare, home nursing, health visiting, midwifery and others), and to provide for the co-ordination of these services with the other services in the plan.

(b) County and county borough councils will normally provide most of these local services. The exact allocation of responsibility between the joint authority and the individual county and county borough councils will be finally settled in each case in the approved area plan; but the principle will be that services belonging to the hospital and consultant sphere will fall to the joint authority while other local and clinic services will fall to the individual councils.

(c) Child welfare duties will always fall to the authority responsible for child education under the new Education Bill.

(d) New forms of service, e.g., for general dentistry and care of the eyes, will be considered with the professional and other interests concerned. In the case of dentistry the report of the Teviot Committee is awaited.

6. *Organisation in Scotland.*

(a) The scope and objects of the service will be the same in Scotland as in England and Wales, but subject to certain differences due to special circumstances and the geography and existing local government structure in Scotland.

(b) The local organisation in Scotland will differ from that in England and Wales and will be on the following lines:—

(i) Regional Hospitals Advisory Councils will be set up for each of five big regions. The Councils will be advisory to the

Secretary of State on the co-ordination of the hospital and consultant services in each region.

(ii) Joint Hospitals Boards will be formed by combination of neighbouring major local authorities (county councils and town councils of large burghs) within the regions to ensure an adequate hospital service in their areas. The Boards will take over all responsibility for the hospital services of the constituent authorities (including services like the tuberculosis dispensaries, which essentially belong to the hospital and consultant field) and will also arrange with voluntary hospitals.

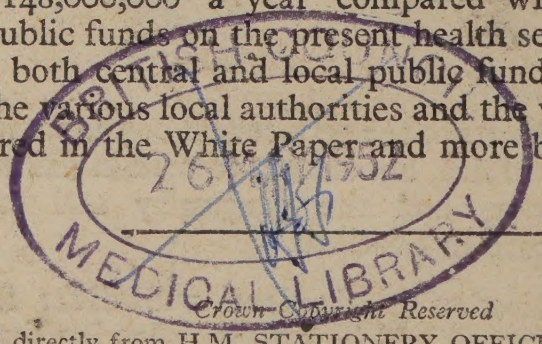
(iii) The joint boards will prepare a scheme for the hospital service in their areas and submit this to the Secretary of State, who will consult the Regional Hospitals Advisory Council before deciding to approve or amend it. The powers of the Secretary of State will be strengthened to enable him to require major local authorities to combine for any purpose proved necessary after local enquiry.

(iv) Education authorities (county councils and town councils of four cities) will retain responsibility for the school health service and clinics, until the medical treatment part of the school service can be absorbed in the wider health service. Existing major health authorities (county councils and town councils of large burghs) will normally retain responsibility for the ordinary local clinic and similar services; the necessary co-ordination will be secured through their membership of the joint hospital boards and through the Local Medical Services Committees (below).

(v) Local Medical Services Committees—advisory bodies consisting of professional and local authority representatives—will be set up over the same areas as the Joint Hospitals Boards. The Committees will advise the Secretary of State on local administration of the general practitioner service and will provide liaison between the different branches of the service.

7. *Finance.*

It is estimated that the cost of the new National Health Service will be about £148,000,000 a year compared with about £61,000,000 spent from public funds on the present health services. The cost will be met from both central and local public funds. The arrangements as affecting the various local authorities and the voluntary hospitals are fully considered in the White Paper and more briefly in this paper.



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